# Instructions for Completing Form FA-19
## (Level of Care Assessment Form for Nursing Facilities)

### Purpose

Form FA-19 assists Hewlett Packard Enterprise (HPE) in determining the required service level for a recipient and whether the recipient meets the level of care criteria for nursing facility placement. Submit form FA-19 under any one of the following conditions: (1) prior to a recipient's admission to a nursing facility, (2) prior to expiration of a recipient's time-limited Level of Care (LOC) screening, (3) when a recipient changes from a non-Medicaid payment source to Medicaid, (4) when a recipient is determined eligible for Medicaid benefits retroactively and/or (5) when a recipient's level of service changes and a new LOC screening is needed.

### Screening Type

Reason for Screening: Indicate the reason for the screening. An explanation for each reason is shown in the following table.

| Reason | Explanation |
|---|---|
| Initial Placement | The recipient is being admitted into the Nursing Facility for the first time. |
| Retro Eligibility | The recipient was determined eligible for Medicaid benefits retroactively. |
| Service Level Change | A recipient's service needs have changed. For example, the recipient was not Ventilator Dependent, but now is, or vice versa. |
| Time Limitation | The previous LOC assessment was time limited and is close to expiration. Submit form FA-19 at least five days prior to the expiration of the current assessment. |

Service Level: Indicate the level of service you are requesting for the recipient.

| Service Level | Explanation and Special Instructions |
|---|---|
| Standard | Standard Nursing Facility service is required. No attachments are required. |
| Pediatric Specialty Care I | When requesting this level of service, you must attach form FA-22 (Screening Request for Pediatric Specialty Care Services). |
| Pediatric Specialty Care II | When requesting this level of service, you must attach form FA-22 (Screening Request for Pediatric Specialty Care Services). |
| Ventilator Dependent | The recipient requires ventilator support for a minimum of 6 hours within a 24-hour period. You must attach medical documentation that confirms this when requesting the Ventilator Dependent service level. |

Date: Enter the date the request is submitted to HPE.

## Requesting Facility or Provider Information

Name: Enter the last name and first name of the person completing the form.

Telephone: Enter the phone number of the person completing the form.

Fax: Enter the fax number of the person completing the form.

Organization Name: Enter the name of the provider or organization requesting the assessment.

Organization Address: Enter the address, city, state and zip code of the provider or organization requesting the assessment.

## Recipient Information

Name: Enter the last name and first name of the recipient.

Street Address: Enter the recipient's mailing address, city, state and zip code.

Social Security Number: Enter recipient's Social Security Number.

Date of Birth: Enter recipient's Date of Birth.

Medicaid ID: Enter the recipient's 11-digit recipient ID number.

## Medical History

Diagnoses/Diagnosis Code(s) Related to Placement: In the space provided, enter up to three diagnoses or diagnosis codes that justify nursing facility placement and the level of service you are requesting. Do not list short-term, resolving diagnoses such as bronchitis, urinary tract infection, pneumonia, dehydration and/or diarrhea.

Current Medications: List medications the recipient is currently taking.

Medication Administration: Can recipient safely self-administer medications? Answer this question by selecting "Yes" or "No." If "No" is selected, list the barriers preventing the recipient from safely administering their medication such as "poor eyesight," "forgetful" or "unable to open bottles."

Special Needs: Select all items that pertain to the recipient's care needs.

- If the recipient requires Durable Medical Equipment (DME), select "DME" and use the space provided to list equipment the recipient is currently using.
- If the recipient has a need not listed in this section, select "Other" and specify the need.

Use the last line in this section to provide details about the frequency and duration of any treatments, the stage/grade/size/location of wounds and/or other details regarding the recipient's special need(s).

Activities of Daily Living (ADL): For each ADL, select the Level of Care (only one) that applies to the activity under the Self Performance column. A description for each Level of Care is shown in the following table.

| **Level of Care** | **Description** |
|---|---|
| Independent | The recipient can independently perform the activity or requires no assistance to perform the activity with use of an adaptive device. |
| Supervision | To ensure the recipient's safety, a caregiver must oversee the activity. |
| Limited Assistance | The recipient requires limited help with the activity. |

| | |
|---|---|
| Extensive Assistance | The recipient requires extensive help with the activity. |
| Total Dependence | The recipient is dependent upon caregivers to complete the activity. |

For each ADL, select the level of support the recipient requires (only one) in the Support Provided column. A description for each level of support is shown below.

| **Support Provided** | **Description** |
|---|---|
| No Setup or Help | The recipient does not require setup or help for the activity. |
| Setup Help Only | The recipient requires setup only for the activity. |
| One Person Physical Assist | The recipient requires help of one person for the activity. |
| Two Person Physical Assist | The recipient requires help of two people for the activity. |

For Bladder/Bowel Function, select whether the recipient is Continent, Incontinent or Requires a Catheter in the Support Provided column next to each activity.

For Locomotion, enter any Assistive Devices the recipient is using in the Support Provided column.

Instrumental Activities of Daily Living (IADL): If the recipient requires meal preparation and/or homemaking services related to personal care, select the level of care next to that item in the Self Performance column. See above table for descriptions of Level of Care.

Recipient's need for Supervision: Select all items that pertain to the recipient's actions.

## Screener Certification

Signature and title of person completing the form are required.

## Form Submission and Notice of Decision

Upon completion, fax this form to 1-855-709-6847. HPE will review the request, make a determination and notify the requestor by fax. The requestor will also receive a system-generated letter. The letter contains the official determination. If HPE determines the recipient does not meet the level of care criteria for nursing facility services, both the requestor and the recipient will be notified by mail with a Notice of Decision (NOD) letter.